RECORDS REQUEST

I authorize the release of dental records and most recent x-rays for the patient(s) listed below:

Patient Name: ____ DOB: __________________

Patient Name: ____ DOB: __________________

Patient Name: ____ DOB: __________________

Patient Name: ____ DOB: __________________

Forward the records to:

Dentistry for Children of West Essex, LLC
412 Pleasant Valley Way
West Orange, New Jersey 07052

Email x-rays to:

DCWE@the-big-grin.com

Parent's Name: ____

Printed

Parent's Signature: ____ date: _______